"A.) Does the available medical documentations support an impairment of such severity that would cause the claimant's inability to function at any gainful employment?

B.) If the answer to A is yes, please explain how the medical documentation supports impairment and advise what impairments the claimant has.

C.) If the answer to A is no, please advise what documentation is lacking to support an impairment."

10/1/2002 - MetLife's medical consultant, Dr. Silver stated to MetLife:

> **"Ms. Brownfield has never had an EMG, nerve conduction velocity study completed**, or an orthopedic surgical spine specialist consultation completed. **She has not had a myelogram or myelographically enhanced UT scan performed.** Dr. Silver went on to say, "... it would be prudent for Ms. Brownfield to see a board-certified neurosurgeon and a board-certified neurologist. **It would be appropriate for Ms. Brownfield to have an EMG and nerve conduction velocity studies performed."**

Unbeknownst to Dr. Silver, he was never given the complete file on Brownfield! The suggested tests had already been performed and were already in MetLife's files! The Administrative Record of MetLife's confirmed that there were x-ray findings done on 8/9/01. There were myelograms done on 8/3/01 and 11/7/01. There were also nerve conduction

studies done on 12/28/01 and reported 6/10/02. All of the above documents confirmed abnormalities. All of the tests Dr. Silver stated hadn't been performed were already in the Administrative Record and were in MetLife's possession before they engaged Dr. Silver. Copies of these documents were later sent to Brownfield from MetLife when she requested a complete copy of her file.

Lacking this requested information to form an accurate opinion, Dr. Silver, who it turns out is not even licensed in the state he practices medicine, tells MetLife (his employer) that based on the medical evidence provided to him or lack thereof, he can not determine that Brownfield is disabled!

During the final months leading up to MetLife's decision to deny disability benefits, Brownfield's employer "Kodak" (out of whose pocket would come the payment of benefits) conspired to deny Brownfield's disability benefits by calling **every week** and forming such an affinity for Kodak's representative, "Mike" that they were on a first name basis.

From MetLife's internal diary:

> *"09/16/2002 INCOMING CALL FR [from] ER [employer] MIKE PRIBANICH, ADVISED THAT APPEAL IS STILL PENDING."*

> *"09/24/2002 INCOMING CALL FROM ER [employer] MIKE PRIBANICH CALLED FOR STATUS OF APPEAL."*

"09/30/2002 INCOMING CALL FROM ER [employer] FR MIKE PRIBANICH, ADVISED CURRENTLY STILL UNDER REVIEW AT THE APPEALS LEVEL."

"10/08/2002 INCOMING CALL FROM ER [employer] FR MIKE PRIBANICH, STATUS OF APPEAL. ADVISED MIKE APPEAL HAS BEEN UPHELD [benefits denial] & LETTER WENT OUT DATED 10/3/02."

"10/15/2002 INCOMING CALL FROM ER [employer] SPOKE TO MIKE PRIBANICH, HE INDICATED HE SPOKE TO EE [Employee – Brownfield] WHO ADVISED HIM SHE HAD CALLED OUR OFFICE FOR INFORMATION & HAS NOT HEARD ANYTHING FROM US... ADVISED THE UPHOLD LETTER WENT OUT TO EE [Brownfield] ... MIKE SAID HE WILL CALL EE & ADVISE HER TO SEND REQUEST IN WRITING."

From the above, it is clear that Kodak wanted to save money and MetLife wanted to keep a valuable client (Kodak) – a win/win for both.

Immediately after the above listed series of events, EKINSELLA@METLIFE.COM from MetLife notified TAMMY.ROY@KODAK.COM from Kodak of Brownfield's denial of benefits, Kodak thanked MetLife for denying the claim:

"E-MAIL SENT TO ER – LTD DENIAL NOTIFICATION. LTD DENIAL"

"THANKS, WE WILL NOTE ON HER FILE HERE"

MetLife closed the administrative record with the final denial.

March 13, 2003 - Brownfield filed a complaint in this action.

April 17, 2003 - MetLife answered the complaint.

October 27, 2003 - Brownfield filed its Response and Memorandum of Points and Authorities regarding Trial on the Administrative Record.

November 26, 2003 - A trial on the administrative record was heard by the district court.

April 7, 2004 - The Court mistakenly issued a judgment on a non-existing motion for summary judgment.

April 13, 2004 - The district court issued a corrected judgment to reflect the fact that the matter was heard as a trial on the administrative record.

May 5, 2004 - Brownfield's Notice of Appeal was timely filed.

REASONS FOR GRANTING OF THE PETITION

I. THE SUPREME COURT'S RULING IN *BLACK & DECKER v. NORD* HAS CREATED FURTHER PROBLEMS IN ADMINISTERING DISABILITY CLAIMS

The Supreme Court's ruling in *Black & Decker v. Nord*, 123 S. Ct. 1965 (2003) is now the leading case affecting disability law. A review of the oral arguments before the U.S. Supreme Court and the later actions that both the New York State Attorney General, Eliot Spitzer and the California Insurance Commissioner, John Garamendi were forced to take, clearly shows the devastating consequences that Black & Decker has had on those that become disabled. These unintended consequences have worsened the already serious injustice that continues to allow insurance companies to deny thousands of disabled persons their rightfully due benefits.

THE SUPREME COURT OF THE UNITED STATES
ORAL ARGUMENT
Black & Decker Disability Plan, v. Kenneth L. Nord
- Case No. 05-469

On Monday, April 28, 2003, Lee T. Paterson appeared before the U.S. Supreme Court on behalf of the Petitioner, Black & Decker, and stated:

> "The Ninth Circuit has adopted a treating physician rule in ERISA cases which requires the plan administrator to either accept the opinion of a treating physician or to reject that opinion by

specific legitimate reasons based upon substantial evidence. The Ninth Circuit says that this rule gives special weight, deference, and a presumption to the opinions of treating physicians...

The Secretary of Labor has adopted regulations, which were effective in January 1 of 2002, which requires a plan administrator to obtain the opinion of an expert medical professional to advise him regarding medical opinions and to be able to provide an expert medical opinion to the claimant if he requests it...

There has always been a requirement under ERISA and the regulations that plan administrators explain the reasons for his denial of a claim... They were given by the plan administrator in writing to the claimant. He told the claimant that he was, in fact, denying the claim based on the opinion of Dr. Mitri... He told them that part of the reason for denying the claim was the fact that the plan administrator had asked the claimant to please have his treating physicians comment on the opinion of Dr. Mitri. He did that twice. He did it in writing. And in neither case did the respondent respond with any – from the treating physicians – with any response from their – the treating physicians."

Justice Ginsburg stated:

"Why was it so clear? First of all, if you take the treating physician – was given an opportunity to comment on the expert's opinion, on Dr. Mitri's opinion. Here it is. Not one word from either the treating physician or the – what is it? The

> orthopedist who was – who was called in by the treating physician. So the expert stands out there all alone with no comment on it."

The facts of Brownfield's case are quite different from Black & Decker v. Nord. Both Brownfield and her treating physician were unaware, until after MetLife closed the administrative record, that MetLife had even engaged a physician for an opinion. After the administrative record was closed, no other evidence was allowed to be considered by the trial judge. Brownfield gave evidence to the Court to supplement the administrative record to counter what MetLife and their physician had stated, but the court could not consider it.

During the oral argument in the Black & Decker case, Mr. Paterson stated:

> "The Ninth Circuit's treating physician rule is a categorical rule based upon the assumption that a treating physician's opinion is superior to other medical opinions... and that the Plan administrator in the Ninth Circuit's rule requires the plan administrator to give deference, special weight, and a presumption in favor of Dr. Hartman's opinion even though he referred respondent to specialists for evaluation and even though he has no apparent expertise in back injuries or back pain... <u>In every case, the ERISA plan administrator should weight not only the source of the opinion, but also the experience, the testing, the treatment, and the credentials of the physician</u>."

Again, the facts of Brownfield's case were quite different. MetLife would not refer Ms. Brownfield to an independent medical examiner, nor give the physician they hired for an opinion the medical evidence in their possession supporting Ms. Brownfield's case. When MetLife's physician requested the additional medical documentation in MetLife's possession, MetLife ignored him. Contrary to what Mr. Paterson claimed should be done in "every case", the plan administrator in Brownfield v. MetLife did not weight "the source of the opinion," "the experience, the testing, the treatment or the credentials" of their own physician. Their physician did no testing or treatment and was unable to properly evaluate the majority of the medical evidence, because it was never provided to him by MetLife. Neither the plan administrator, Kodak nor MetLife, even checked MetLife's physician's credentials. If this had been done, they would have found that MetLife's physician did not have a license, nor could he renew his license in the state he stopped practicing medicine due to the malpractice decisions against him and his disciplinary record by the Arizona Medical Board.

Since Black & Decker v. Nord, the courts in the Ninth Circuit have effectively checked to see if the plan administrator had a physician's opinion claiming that the disabled claimant was not entitled to disability benefits. Once the Judge finds that there was the above physician's opinion, the courts will automatically rule for the insurance company.

This was clearly apparent in the Brownfield case. After MetLife claimed that they were relying on the opinion of their physician, the court did not even

comment on anything in Brownfield's brief's, but took MetLife's Statement of Fact and Conclusions of Law nearly verbatim and inserted it into an opinion on a nonexistent Motion for Summary Judgment replete with many other errors. A corrected ruling was subsequently filed for the trial on the administrative record. Both rulings were rubber stamped with the presiding judge's name.

As previously stated by Mr. Paterson, "The Ninth Circuit has adopted a treating physician rule in ERISA cases which requires the plan administrator to either accept the opinion of a treating physician or to reject that opinion by specific legitimate reasons based upon substantial evidence."

The treating physician rule, as adopted by the Ninth Circuit, may have had a negative aspect in regards to the treating physician possibly being a bit biased for their patients. However it did have the effect of providing substantial justice. Requiring "the plan administrator to either accept the opinion of a treating physician or to reject that opinion by specific legitimate reasons based upon substantial evidence," had the effect of causing the always conflicted plan administrator to actually present evidence to support their denial of disability benefits. If this is done and the treating physician is notified of his reasoning, the treating physician gains a chance to explain or counter the plan administrator's physician's opinion. In Brownfield's case, her treating physician would have notified MetLife's physician that MetLife had not provided him (MetLife's physician) with most of the pertinent medical examinations or findings. Prior to its demise, the treating physician's rule would assure that

real justice was received by thousands, and potentially millions, of truly disabled persons.

Brownfield's case is a perfect example of how insurance companies have learned to manipulate a body of laws established to protect the disabled in order to deny benefits to thousands of truly deserving, whom by no fault of their own, can no longer work.

The U.S. Supreme Court stated in its decision in *Black & Decker v. Nord*, 123 S. Ct. 1965 (2003) "Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician ... nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation."

In Brownfield's case, MetLife arbitrarily closed the administrative record thereby preventing Brownfield's reliable evidence from being heard by the court. Attempting to have this evidence heard, Brownfield submitted to the court reliable evidence including the opinions of her treating physician to supplement the administrative record, but the courts would not consider it.

Additionally, MetLife's consultant's opinion could not be considered "reliable evidence" because MetLife did not provide their consultant with the critical information in their possession for him to form an educated opinion.

After Black & Decker v. Nord, insurance companies have become even more brazen in denying

disability claims. It has become so out of control, that New York State Attorney General Eliot Spitzer went after UnumProvident – one of the worst offenders. The investigations focused on assertions that UnumProvident had inappropriately denied claims for benefits under individual and group long-term disability insurance policies. In a settlement on November 19, 2004, UnumProvident agreed to impose sweeping reforms that will protect disabled workers nationwide. The settlement resolves issues relating to investigations into UnumProvident's claims handling practices. Under the terms of the settlement, UnumProvident and its subsidiaries have agreed to:

- "reassess the claims of approximately 200,000 individuals whose claims for group or individual long-term disability benefits were denied;

- restructure their claim handling procedures to ensure that all future claims are reviewed in a fair and objective manner, including an agreement to:

- select medical examiners based solely on merit, and ensure that those examiners review all relevant records before reaching a determination;

- require personnel making impairment determinations to certify that their determinations were based upon a review of all the relevant evidence;

- prohibit company personnel from trying to influence the outcome of disability claim appeals; and

- grant significant weight to findings of disability by the United States Social Security Administration."

MetLife operated contrary to all four of the requirements stated above in Brownfield's case, yet they are not required to follow this settlement.

The Unum lawsuit and subsequent settlement was obviously necessary due to how claimants like Brownfield were treated based upon the lack of direction and good law affecting disability claims handling procedures.

Though UnumProvident has agreed to change their claims handling procedures, as can plainly be seen from the aforementioned facts, MetLife and other insurers are continuing to practice the same unfair denial process that UnumProvident was investigated and fined for in 2004.

In the case of *Black & Decker v. Nord*, MetLife was also the insurance company. That ruling has made it easier for all insurance companies to improperly deny disability benefits. Currently, except for UnumProvident, MetLife and other insurance companies have been and will continue to deny disabled people benefits, at will, through the trickery detailed above. Because of the implications of Black & Decker v. Nord, the only fact the courts now needs to focus on is whether the Claims Administer obtains an opinion from

their physician that states he did not find the claimant disabled. The disabled person is then presented with the extremely difficult, if not impossible task, of overcoming the "Abuse of Discretion Standard" to prevail against the insurance company. This is like forcing a disabled person to climb Mr. Everest in a wheelchair. It is technically possible, but really can't be done.

The majority of lawsuits against UnumProvident thus far have been settled out of court and the "company says most of the cases ending up in trial are won on their end". This statement only proves how dreadful the current law is when it is forcing disabled people to settle and receive pennies on the dollar of their policies.

The class action filed against UnumProvident in San Francisco federal court also **found UnumProvident employed biased medical examiners and improperly destroyed medical reports, in addition to other reports.**

A former in-house physician at UnumProvident, Dr. McSharry, sued the company in July 2002 after being fired that previous January. McSharry says UnumProvident pressured him, as well as the other doctors, to go along with claim handlers' decisions to terminate claims. Dr. McSharry says he was fired after he refused to sign off on claims.

On the television news show 60 Minutes, UnumProvident's bad faith business practices were disclosed by former Unum employees and have been confirmed by over a dozen current and former

employees including former vice presidents of UnumProvident. The former employees disclosed information on UnumProvident saying the workers were told they must meet monthly targets that would come from the directors or above as to the sum of money that must be met by the end of the month in closures.

In 2003, shortly after the ruling in Black & Decker, California Insurance Commissioner John Garamendi began an exhaustive investigation into allegations of unfair claims settlement practices by the Tennessee-based UnumProvident. The investigation uncovered more than 25 business practices that violated California law, including:

- Knowingly applying the wrong definition of "total disability" in claims handling;

- Selectively and inappropriately using independent medical exams and other medical information to the company's own advantage.

In 2005, UnumProvident settled with the California Insurance Commissioner and was required to pay an $8 million fine. The agreement settles a dispute over thousands of claims by California policyholders who were unfairly denied benefits. UnumProvident will change its policy language and claims handling procedures in dealing with those disputed claims, and all future claims.

Commissioner John Garamendi announced that the settlement will:

> "significantly improve consumer protection and profoundly impact how disability policies are handled in California...This is a new day for policyholders whose disability insurance claims have been wrongly denied by insurance companies. I am making it clear today that policies sold in California will deliver what they promise. In this state, insurers will live up to their end of the bargain."

Important aspects of the settlement include:

• A higher standard must be met for the insurer to reject a claimant's doctor's opinion on disability, and the reasons must be documented in claim files;

• Claimants or their doctors may request an independent medical examination.

MetLife was the insurance company and Claims Administrator in Brownfield's case. After Unum's California settlement, if Brownfield had Unum as the Claims Administer, her doctor's opinion would not have been ignored under Black & Decker v. Nord, but would have had "a higher standard" of review. Brownfield was forced into the Black & Decker "Abuse of Discretion" review standard. Brownfield requested an independent medical examination on numerous occasions, but was denied. MetLife did and continues to do everything for which UnumProvident has been fined and has agreed not to do again.

The Supreme Court of the United States should recognize that there is still a major problem with the laws affecting the disabled. The Court should be part of

the solution and not part of the problem. The Court should now understand that their decision under Black & Decker v. Nord has only made the problem worse for disabled people. **Disabled people should not have to wait for State Attorney Generals and State Insurance Commissioners to receive justice.**

II. REVIEW IS WARRANTED TO RESOLVE AN IMPORTANT DISPUTE AMONG THE CIRCUITS

During the Brownfield case, MetLife frequently used the phrase, "There is no evidence in the administrative record to support ..." Their use of this phrase was especially harmful to Petitioner's case when used in reference to issues involving their own conflicts of interest. For example, MetLife claimed among other points that Brownfield's treating physician's informed MetLife's claims administrator that he could not be objective. This was a complete fabrication. Brownfield's physician prepared a statement countering that assertion, yet it was not allowed into evidence. Also, not allowed into evidence was a letter sent to MetLife by Brownfield's doctor, where it was kept in both Brownfield's and Kodak's personal file. That letter predicted her condition decades before it actually manifested itself. Just like the documents that MetLife's physician consultant requested, that were already in their files, MetLife denied ever having received that document. Also not admissible was documentation clearly showing that the physician/consultant, whom MetLife used to support their case, was not licensed to practice medicine in the state he claimed. To make matters worse, that same physician/consultant had numerous medical complaints

and malpractice judgments against him. All these important and crucial facts were not allowed into evidence.

The Fifth Circuit recognizes the impossibility of proving a conflict of interest on the part of a plan administrator without going beyond the administrative record. See *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346, 356 (5th Cir. 2004) ("There is no practical way for the extent of the plan administrator's conflict of interest to be determined without the arbitrator going beyond the record of the administrator.") The Ninth Circuit in general and the district court in this particular case take the opposite view. Indeed, in her opening brief to the Ninth Circuit, petitioner documented numerous examples of conflicts of interest on the part of Respondent. Some, if not all, of the evidence necessary to prove such a conflict was outside the administrative record.

The Fifth Circuit allows a plaintiff to go outside the administrative record to determine the level of conflict of interest that existed. The Fifth Circuit would have allowed Brownfield's physician's statement countering the fabrications that MetLife has attributed him. The Fifth Circuit would have allowed the introduction into the administrative record of the physician's document which predicted the genetically passed on auto immune disease that Brownfield now suffers. The Fifth Circuit would also allow information to supplement the administrative record regarding the fact that MetLife used an unlicensed consultant to determine Brownfield's medical condition and therefore deny benefits.

As pointed out, *supra*, the Fifth Circuit allows evidence outside the administrative record to show how a plan administrator administered a claim under a conflict of interest. *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346, 356 (5th Cir. 2004). In contrast, the Ninth Circuit places limits on the admissibility of evidence considered "outside" the administrative record. *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 944, 943 (9th Cir. 1995). In Brownfield's case, the district court was presented with substantial evidence by Petitioner's treating physicians indicating that she was in fact disabled. Additionally, Petitioner presented a substantial amount of evidence indicating that Respondent was conflicted as a claims administrator

More importantly, if the Ninth Circuit had followed the same decisions as the Fifth Circuit, they would allow in additional information outside the administrative record on the issue of conflict of interests with the effect of raising the standard to the "Heightened Scrutiny Standard." Applying this standard, the Ninth Circuit would have reversed the District Court's decision awarding disability benefits to Brownfield.

III. THERE IS A SIMPLE SOLUTION TO CORRECT THE EXISTING PROBLEMS AND LACK OF GOOD LAW NOW SERIOUSLY AFFECTING DISABLED PERSONS

Bias and greed are the main foes to an honest administration of a disability claim. Insurance companies have nothing to loose and everything to gain

by denying a disability claim. Physicians sometimes show bias toward their clients. This includes both physicians for the Claimant and the Claims Administrator. There is a simplified solution to this bias problem that will provide substantial justice to the disabled. The following procedure should be implemented:

1. The Claimant files a claim and sends evidence of his/her disability to the Claims Administrator.

2. The Claims Administrator has a maximum of 45 days to review the claim. To ensure that all claims are reviewed in a fair and objective manner, the Claims Administer will: Select medical examiners based solely on merit, and ensure that those examiners review all relevant records before reaching a determination; Require personnel making impairment determinations to certify that their determinations were based upon a review of all the relevant evidence; Prohibit company personnel from trying to influence the outcome of disability claim appeals; and Grant significant weight to findings of disability by the United States Social Security Administration. A list of all the documents reviewed must be prepared by the medical examiners.

3. If the Claims Administrator's denies the claim, they must provide the reasons for the denial and must then send copies of all the documents in Administrator's claims file

including a list of the documents to the Claimant.

4. The Claimant has 60 days from the date of the denial to provide additional medical evidence to the Claims Administrator. The Claimant or their doctors may request an independent medical examination during this time.

5. The Claims Administrator then has 45 days from the date of the appeal to make their final determination as to whether they will pay the disability benefits.

6. If the Claims Administrator denies the appeal, the Claimant may file suit in court.

7. The court then reviews the case de Novo. The de Novo standard of review allows the court to consider all relevant evidence, similar to evaluations under Social Security disability reviews.

If this procedure looks familiar, it should. Most, if not all of it, was taken from the settlement agreements UnumProvident (the largest disability insurance company) signed in New York and California. Unum would not have agreed to this if it was not fair. This procedure will provide justice for all concerned. With the additional fairness and relevant information allowed into evidence, attorneys will not be willing to take a case on contingency if they truly do not believe they have a good chance of winning. Additionally, Claims Administrators are not going to waste their client or

stockholders money if they know that the Court will, more than likely, side with the Claimant.

State Attorney Generals and State Insurance Commissioners should not have to fix problems created with bad law. The above procedure should be followed in Brownfield's case. The court should allow MetLife's physician the opportunity to review all of the medical information. Brownfield should be able to request an independent medical examination. Brownfield's physician's opinion should be reviewed under a higher standard before being rejected. Significant weight should be given to her receiving Social Security benefits. If MetLife still denies Brownfield claim, a court should review the case de Novo.

CONCLUSION

These laws have a profound effect on disabled people's lives. There are "more than 2.5 million claims for disability benefits [filed] each year," *Cleveland v. Policy Management Systems Corp*, 526 U.S. 795, 803 (1999).

It is of exceptional importance that people who are truly disabled receive disability benefits. The disabled must have these benefits awarded in order to continue their lives and receive medical treatment. Actual survival is at stake if the disabled can no longer work and have no source of income. There should be a system of laws designed to protect disabled workers like Brownfield. Disabled people are losing their homes and their will to live when stripped of the disability benefits which are due them. These benefits are truly needed in the event of a disability to cover medical care costs and

the continuing costs required for daily living. The actual effect of the loss of disability benefits to many disabled persons is the equivalent of a death sentence.

The justices of the United States Supreme Court have the power to stop the unintended consequences of court cases that continue to severely affect disabled people lives. They have the power to unify the rulings of the clashing Circuits.

The disability laws currently existing are not working. Presented before this honorable Court is a perfect example of how insurance companies have learned to manipulate the system to benefit them and severely harm disabled people. Petitioner implores the United States Supreme Court to take the time to hear this case not only to help her, but to help the thousands, if not millions, of disabled persons who are and will continue to suffer under the current unjust law that effect the administration of disability plans.

For all the foregoing reasons, petitioner respectfully request that the Supreme Court grant review of this matter.

Respectfully Submitted,

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c/o LAW OFFICES OF
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(any footnotes trail end of each document)

No. 04-55833

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KYLE G. BROWNFIELD,
Plaintiff - Appellant,
v.
METROPOLITAN LIFE INSURANCE COMPANY,
Defendant - Appellee.

September 14, 2005, Filed

NOTICE: RULES OF THE NINTH CIRCUIT COURT OF APPEALS MAY LIMIT CITATION TO UNPUBLISHED OPINIONS. PLEASE REFER TO THE RULES OF THE UNITED STATES COURT OF APPEALS FOR THIS CIRCUIT.

COUNSEL: For KYLE G. BROWNFIELD, Plaintiff - Appellant: Ellsworth Vines, Esq., ELLSWORTH, VINES LAW OFFICES, Irvine, CA.

For METROPOLITAN LIFE INSURANCE COMPANY, Defendant - Appellee: Joseph C. Faucher, Esq., REISH & LUFTMAN, Los Angeles, CA.

OPINION: MEMORANDUM *

JUDGES: Before: SILVERMAN and CALLAHAN, Circuit Judges, and DUFFY***, District Judge.

Kyle G. Brownfield appeals the district court's judgment, following trial on the administrative record, in favor of Metropolitan Life Insurance Company ("MetLife") in Brownfield's suit pursuant to the Employee Retirement Income Security Act ("ERISA"). We have jurisdiction pursuant to 28 U.S.C. § 1291, and we affirm. [1]

Brownfield sought long-term disability benefits under a plan sponsored by her former employer, Eastman Kodak Company. Determinations of disability under Kodak's Plan are committed to the discretion of MetLife as the Claims Administrator. MetLife denied Brownfield's original benefits application and affirmed that decision following administrative review. Where the plan gives the administrator discretionary authority, the court's review is for abuse of discretion,[2] *Eley v. Boeing Co.*, 945 F.2d 276, 278 (9th Cir. 1991), unless the presence of a serious or substantial conflict of interest between the fiduciary and its beneficiaries is demonstrated, *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109 (9th Cir. 1999).

In order to establish a serious conflict of interest, a beneficiary must come forward with "material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995). Brownfield has failed to sustain this burden and we agree with the district court that a deferential standard of review is appropriate.

Brownfield's contention that the district court committed reversible error by neglecting its adjudicative and administrative responsibilities is wholly without merit. Finally, we decline to consider the untimely arguments raised for the first time in Brownfield's reply brief. *See Smith v. Marsh*, 194 F.3d 1045, 1052 (9th Cir. 1999) ("Arguments not raised by a party in its opening brief are deemed waived."). We affirm the district court's judgment in favor of MetLife.

AFFIRMED.

Footnotes

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

*** The Honorable Kevin Thomas Duffy, United States District Judge for the Southern District of New York, sitting by designation.

n1 Brownfield's requests for judicial notice are denied.

n2 This circuit has been inconsistent in labeling the appropriate standard of review. Some cases refer to the standard as "arbitrary and capricious" (as used by MetLife in the Red Brief), while others use the term "abuse of discretion." *Compare Eley*, 945 F.2d at 278 (abuse of discretion) *with* Dytrt v. Mountain State Tel. & Tel. Co., 921 F.2d 889, 894 (9th Cir. 1990) (arbitrary and capricious). "The standards differ in name only." *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1321 n.1 (9th Cir. 1995).

No. 04-55833

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KYLE G. BROWNFIELD,
Plaintiff - Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant - Appellee.

Judgment

Appeal from the United States District Court for the Central District of California (Santa Ana).

This cause came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California (Santa Ana) and was duly submitted.

On consideration whereof, it is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is AFFIRMED.

Filed and entered 9/14/05.

No. 03-280

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

KYLE G. BROWNFIELD,
Plaintiff

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant.

Filed 4/09/2004

JUDGMENT

The Court, having considered defendant's motion for summary judgment in the above entitled matter, and the Honorable Alicemarie H. Stotler, District Judge, having duly rendered a decision on April 7, 2004.

IT IS ORDERED AND ADJUDGED that:

The plaintiff take nothing against defendant in this action, that judgment is hereby entered in favor of defendant, and that defendant recover its costs of this action.

Alicemarie H. Stotler
United States District Judge

No. 03-280

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

KYLE G. BROWNFIELD,
Plaintiff

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant.

Filed 4/14/2004

CORRECTED JUDGMENT

The Court, after trial on the administrative record in the above entitled matter, and the Honorable Alicemarie H. Stotler, District Judge, having duly rendered a decision on April 7, 2004.

No. 04-55833

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KYLE G. BROWNFIELD,
Plaintiff - Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY,
Defendant - Appellee.

Filed 11/3/05

ORDER

JUDGES: Before: SILVERMAN and CALLAHAN, Circuit Judges, and DUFFY*, Senior Judge.

Judges Silverman and Callahan have voted to reject the petition for rehearing en banc and Judge Duffy so recommends.

The full court has been advised of the petition for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing en banc is denied.

Footnote

* The Honorable Kevin Thomas Duffy, United States District Judge for the Southern District of New York, sitting by designation.

No. 05-1067

IN THE

Supreme Court of the United States

KYLE G. BROWNFIELD,

Petitioner,

—v.—

METROPOLITAN LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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CORPORATE DISCLOSURE STATEMENT
(Rule 29.6)

Metropolitan Life Insurance Company is a wholly-owned subsidiary of MetLife, Inc., a publicly-held company.

ARGUMENT

Respondent Metropolitan Life Insurance Company ("MetLife") respectfully submits its Brief in Opposition to the Petition for Writ of Certiorari ("Petition"), to correct a misstatement of fact and law contained in the Petition.

There Is No Dispute Among The Circuits Regarding Admissibility Of Evidence To Demonstrate A Claim Administrator's Purported Conflict Of Interest Where, As Here, The Disability Benefit Plan Is Funded By The Employer And Not The Administrator

Petitioner seeks long-term disability benefits under an employee welfare benefit plan sponsored by her employer, Eastman Kodak Company ("Kodak"), and governed by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA"). As claim administrator for the plan, MetLife determines eligibility for and entitlement to benefits pursuant to the terms of the plan. MetLife does not fund the plan benefits. Rather, the plan is funded by Kodak. *See Petitioner's Supplemental Appendix* at 11a.

Petitioner misstates the facts and the applicable law when she contends that this Court needs to resolve a conflict among the circuits regarding whether evidence outside the administrative record may be considered to determine whether the claim administrator operated under a conflict of interest. A conflict may result in a heightened standard of review under ERISA where the same party acts both as the claim administrator and funds the benefits payable under the plan. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). By referring to MetLife as the "insurance company" throughout the Petition, (*see, e.g., Petition* at i, 22), Petitioner clearly

seeks to imply that MetLife funds the benefits at issue. Petitioner knows full well, however, that the plan at issue here is funded by Kodak, not MetLife. *See Petition* at 9 (". . . Brownfield's employer 'Kodak' (out of whose pocket would come the payment of benefits) . . ."). There is no possible conflict of interest when MetLife makes claim decisions under Kodak's self-funded plan.

Because of this undisputed fact, there can be no apparent conflict of interest, much less an actual conflict, both of which Petitioner incorrectly asserts. *See Petition* at i-ii, 3, 23-25. There is no dispute among the circuits as to whether evidence outside the administrative record may be considered to demonstrate a conflict of interest where, as here, the benefits are not funded by the claim administrator. By obscuring the plan's funding source, Petitioner has misrepresented the applicable law.[1]

CONCLUSION

For the foregoing reasons, Respondent respectfully requests that the Court deny the Petition for Writ of Certiorari.

Respectfully Submitted,

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[1] Petitioner's "Chronology of Events" is also replete with factual misstatements regarding the contents of the Administrative Record. MetLife respectfully reserves the right to address these misstatements should the Court grant the Petition.